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CHRONOLOGICAL NARRATIVE

State Form 46014 (R2 / 7-99) / HCBS 0008

Annual redetermination date *(month, day, year)*

☐ Aged and Disabled ☐ Autism ☐ ICF / MR ☐ Medically Fragile Children ☐ TBI

INSTRUCTIONS: All remarks must be dated, signed with credentials and reflect the units of service provided.
One unit of service = 1/4 hour.

Name	Medicaid number
Address *(number and street)*	Telephone number
City, state, ZIP code	Waiver effective date *(month, day, year)*

DATE	UNITS OF SERVICE	REMARKS

Signature of Case Manager	Date signed *(month, day, year)*
Name of agency	Case Manager code number